GEORGIA STATE BOARD OF WORKERS COMPENSATION
REHABILITATION REGISTRATION APPLICATION
Instructions and Information

CERTIFICATION REQUIREMENTS

A ***REHABILITATION SUPPLIER*** SHALL HOLD ONE OF THE ABOVE CERTIFICATIONS OR LICENSES. Please submit (1) a copy of the certificate, and (2) the notarized application.

CRC – Certified Rehabilitation Counselor
CDMS – Certified Disability Management Specialist
CWAVES – Certified Work Adjustment & Vocational Evaluation Specialist
CRRN – Certified Registered Rehabilitation Nurse Program
LPC – Licensed Professional Counselor
CCM – Certified Case Manager
COHN – Certified Occupational Health Nurse
COHN-S – Certified Occupational Health Nurse - Specialist

A *Resident Rehabilitation Supplier* (an applicant without any of the above certifications) shall **(1)submit documentation showing that they are scheduled to sit for the examination for CRC, CDMS, CWAVES, CRRN, LPC, CCM, COHN, COHN-S, (2) the notarized application and (3) academic transcript(s)**. In the event a rehabilitation resident does not become certified or licensed by the appropriate licensing board within a two-year period from the date of initial application, the rehabilitation resident shall be disqualified from providing services to injured employees.

TO ELECTRONICALLY FILE, SEE INSTRUCTIONS AND REQUIREMENTS AT (WEBSITE),

OR

TO RETURN APPLICATION VIA U.S. MAIL, SEND APPLICATION, CERTIFICATES, and/or TRANSCRIPTS AND a $100.00 CHECK OR MONEY ORDER TO:

YVONNE R. WATKINS
STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE AND REHABILITATION DIVISION
270 PEACHTREE STREET NW
ATLANTA, GA 30303-1299
404-656-0849

REHABILITATION SUPPLIER REGISTRATION APPLICATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE AND REHABILITATION DIVISION

USE TAB BUTTON TO NAVIGATE FORM

PERSONAL DATA

NAME _____
LAST FIRST MIDDLE

ADDRESS _____

_____

CITY STATE ZIP

PHONE ( ) CELL ( ) FAX ( )

INTERNET EMAIL _____ SS# _____

EMPLOYER _____

ADDRESS _____

PHONE _____

ADDRESS AND PHONE NUMBER TO BE USED FOR BOARD CORRESPONDENCE? HOME ☐ WORK ☐

Any change in address, phone number or e-mail MUST be reported to Yvonne R. Watkins in the Managed Care and Rehabilitation Division at the State Board of Workers' Compensation. Changes sent to other division will NOT be processed.

GENERAL DATA

DO YOU SPEAK OR WRITE IN A FOREIGN LANGUAGE? ☐YES ☐NO

IF YES, STATE LANGUAGE AND NUMBER OF YEARS: _____

ARE YOU ABLE TO COMMUNICATE WITH THE DEAF IN SIGN LANGUAGE: ☐YES ☐NO

HAVE YOU BEEN CERTIFIED OR REGISTERED AS A SUPPLIER BEFORE? ☐YES ☐NO

IF YES, STATE THE SUPPLIER NUMBER ASSIGNED: _____

WERE YOU REGISTERED IN ANY OTHER NAME? ☐YES ☐NO

IF YES, STATE THE NAME(S): _____

EDUCATIONAL DATA

NAME OF SCHOOL	ADDRESS	DATES ATTENDED (MO/YR) (MO/YR) FROM TO	DEGREE OR HIGHEST GRADE COMPLETED

Name(s) listed on Transcripts: _____

_____

_____

****EMPLOYMENT DATA – ATTACHING A RESUME IS *NOT* ACCEPTABLE*****

DESCRIBE YOUR WORK HISTORY BEGINNING WITH YOUR CURRENT OR MOST RECENT JOB. DESCRIBE IN DETAIL THE SPECIFIC DUTIES AND RESPONSIBILITIES FOR EACH JOB. CASE MANAGERS MUST SHOW AT LEAST ONE YEAR EXPERIENCE IN WORKERS COMPENSATION

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

NAME OF SUPERVISOR: _____

DATES FROM AND TO: _____

JOB TITLE: _____

DUTIES: _____

_____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

DATES FROM AND TO: _____

DUTIES: _____

_____

_____

EMPLOYER: _____

ADDRESS: _____

PHONE: _____

DATES TO AND FROM: _____

DUTIES: _____

_____

_____

_____

_____

HAVE YOU EVER HAD ANY BUSINESS OR PROFESSIONAL LICENSE REVOKED, SUSPENDED, OR ANNULLED OR HAD ANY OTHER DISCIPLINARY ACTION TAKEN AGAINST YOU? IF YES, EXPLAIN _____

_____

_____

_____

WILL YOUR PRINCIPAL PLACE OF BUSINESS BE WITHIN THE STATE OF GEORGIA?

HAVE YOU EVER BEEN CONVICTED OF ANY CRIME OR PLED NOLO CONTENDRE IN A CRIMINAL PROCEEDING?

IF YES, EXPLAIN

I HAVE READ, AND AM AWARE OF, O.C.G.A. 34-9-200.1 AND RULE 200.1. ALL OF THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE STATE BOARD OF WORKERS' COMPENSATION TO MAKE ANY INVESTIGATION OF THE FOREGOING INFORMATION. I UNDERSTAND THAT ANY OMISSION OR MISREPRESENTATION MAY RESULT IN REJECTION OR REVOCATION OF REGISTRATION.

PLEASE ALLOW 15 TO 20 BUSINESS DAYS FOR RECEIPT OF CARD.

SIGNATURE_____**DATE**_____

NOTARY_____ **EXPIRATION DATE**_____

RETURN APPLICATION AND CHECK OR MONEY ORDER (IN THE AMOUNT OF $100.00), ALONG WITH CERTIFICATION(S) TO:

YVONNE R. WATKINS
GEORGIA STATE BOARD OF WORKERS' COMPENSATION
MANAGED CARE AND REHABILITATION DIVISION
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